ABSTRACT

The **Maryland Certified Community Behavioral Health Clinic (CCBHC) Planning Grant** project is an initiative of the Maryland Department of Health and Mental Hygiene (DHMH) to establish uniform requirements for Medicaid covered services and payments provided by CCBHCs. In recent years, Maryland's behavioral health delivery system has made significant strides to become more recovery-focused and person-centered. DHMH has also advanced regulatory reforms by moving away from discrete program types, each with separate regulatory standards, to a model in which national accreditation will play a major role in licensing providers. Despite advances, DHMH recognizes that service gaps remain that inhibit the ability of Marylanders with serious behavioral health challenges to access the comprehensive, coordinated quality care they need to maintain their overall health. This initiative will enable Maryland to expand and enhance care coordination, including the expansion of peer-driven care navigation; provide technical assistance to improve the quality of peer and family support; offer enhanced services for veterans; enrich linkages between the correctional behavioral health care system and the community-based system; improve access to crisis support services and more substantial crisis follow-up services; more effectively reach out to individuals and families who have either not engaged with the system or are utilizing only emergency room services; assure the availability of better, and more consistently trained staff, in order to improve the care experience of our clients; and establish and increase access to a more diverse workforce, including more staff with lived experience. The CCBHC Planning Grant Project will also provide opportunities for the State to develop and extend service capacity, including in some rural areas, and address service gaps related to the delivery of: Supported Employment and Assertive Community Treatment (ACT), which are currently limited to certain geographical areas where supply has never been sufficient to meet demand; Targeted Mental Health Case Management which although available in all jurisdictions is underused; Medication Assisted Treatment (MAT) an evidence-based practice (EBP) known to be effective for individuals with opioid addictions but underutilized due in part to stigma; Peer and Family/Caregiver Support a service typically not widely available for all Medicaid-eligible children, but could be broadened under the CCBHC Demonstration. Maryland will use the one year planning period to develop a payment system for CCBHCs following the Certified Clinic Prospective Payment System 1 (CC PPS-1) model. The State selected CC PPS-1 in order to make it possible for as broad a range as possible of providers in Maryland, especially in the rural areas of the state, to pursue CCBHC designation and to fund CCBHC providers sufficiently to provide the high quality coordinated service envisioned by the CCBHC initiative.

Maryland's Certified Community Behavioral Health Clinic (CCBHC) Planning Grant
Table of Contents

SECTION A: STATEMENT OF NEED

A.1:

The Maryland Department of Health and Mental Hygiene (DHMH) serves as the State Mental Health Authority, the Single State Agency (SSA) for Substance Abuse Services, and the State Medicaid Agency. DHMH has four divisions—two of which have significant roles in the administration of Maryland's public behavioral health system: the Behavioral Health Administration (BHA) and Health Care Financing (HCF), as further described below.

- **Behavioral Health Administration:** In July 2014, Maryland's Mental Hygiene Administration merged with the Alcohol and Drug Abuse Administration to form BHA. BHA is responsible for all publicly funded specialty mental health and substance use disorder (SUD) services. BHA maintains a statewide, integrated service delivery system through a continuum of treatment modalities that promotes the public health and safety of patients, participants, families, and communities in all jurisdictions throughout Maryland.
- **Health Care Financing:** HCF implements and manages the Maryland Medicaid program, which serves more than 1.3 million Marylanders. In fiscal year (FY) 2015, funding for Medicaid services for behavioral health was moved from BHA to HCF, which created a specialized unit for behavioral health services that works in close partnership with BHA to administer behavioral health services for individuals funded by Medicaid. BHA handles clinical and system issues, whereas HCF is the lead regarding payment rates, compliance issues, and the development of State regulations and the Medicaid State Plan. BHA and HCF worked closely together to design integration of mental health and substance use services. In partnership with BHA, HCF contracts with ValueOptions, Maryland's Administrative Services Organization (ASO) that administers integrated behavioral health services. The ASO's responsibilities include: provider management and maintenance; operating a utilization management system; service authorizations; paying all Medicaid claims and uninsured claims for individuals receiving mental health services; providing data collection, analysis and management information services (including grant funded SUD services); offering participant and public information; consultation, training, quality management and evaluation services; and managing special projects and stakeholder feedback.

Behavioral health services are funded through both BHA and HCF. Table 1 provides a summary of behavioral health funding sources and 2015 funding levels.

Table 1: Behavioral Health Funding Sources

Source	FY 2015 Funding
Behavioral Health Administration • *Community Services* • *State Operated Institutions* • *Administration*	**$613.2 million** *$313.2 million* *$282 million* *$18 million*
Health Care Finance (Medicaid)	**$782.3 million** (including $448 million federal match)
TOTAL	**$1.4 billion**

Table 1 does not include mental health funding contributed by several local jurisdictions. At the local level, BHA also continues to contract directly with Core Service Agencies (CSA) and Local Addiction Authorities (LAA) to support programs that provide specialized services that are not included in the standard benefit package or do not lend themselves to payment through the

fee-for-service (FFS) system. This consists of approximately $140M in state general funds and $43M in federal funds. Federal grants include block grants for mental health and substance use, PATH, Continuum of Care, Access to Recovery, Healthy Transitions, SBIRT, the new multi-year System of Care grant, Project LIFT, for children, and other CMHS and CMS grants.

Maryland strives to provide a statewide continuum of care with all levels of treatment, where individuals move seamlessly among levels based on their individual needs. Within all 24 jurisdictions in Maryland, there are federal, state and/or locally funded systems for assessment, referral, and treatment of persons with behavioral health disorders. Individuals may self-refer or be referred from a primary or behavioral health provider, other health care professional, the courts or other sources. Maryland operates most of its public behavioral health system under a Medicaid 1115 waiver. Behavioral health care is carved out from physical health care into a FFS program managed by the ASO. Maryland's behavioral health service system approves any willing provider that meets regulatory standards. This competitive environment has created a strong, effective and efficient network of providers. The system has encouraged cooperation within the provider community, since many providers may offer only one or two service types and must rely on partners to provide all of the services needed by their population. At this time, most individuals in need of behavioral health services receive care through an entity approved to deliver either substance use disorder (SUD) or mental health services, and the state regulates these services separately. A growing number of entities provide both services.

A.2:

Maryland has a population of nearly 6 million spread across 24 jurisdictions (Table 2). Maryland has a high median income and generally low poverty rates, but the average cost of living is high. Thus, a family income above the poverty level may not be sufficient to provide adequate food, clothing, health care services and shelter to a family. Areas of economic deprivation and pockets of poverty exist, and racial and ethnic minorities are some the most underserved individuals in Maryland. While Maryland does a reasonably good job assuring cultural competence for much of its African-American community, there are still large pockets where strong stigma prevents people from seeking behavioral health services. This is also true for many Asian, Hispanic, and deaf communities. Table 2 lists prevalence rates of individuals with mental illness and/or SUDs.

Table 2: Behavioral Health Prevalence Rates of Adults and Children[1]

JURISDICTION	Population Over 15 with Substance Issue	ADAA Public System Treated, FY 2014	SED Estimate	SMI Estimate	Adults Diagnosed with Anxiety	Adults Diagnosed with Depression	Adults with Chronic Drinking

[1] ***Data Sources:*** *Population over 15 with Substance Use Issue, ADAA Public System Treated, FY 2014, and Unmet Substance Treatment Need: Unpublished "Estimated Need for Treatment in Maryland", ADAA; SMI (Adults with Severe Mental Illness) and SED (Children and Adolescents with Severe Emotional Disorders): Percentages from NASMHPD NRI; Adults with a Diagnosis of Anxiety, Depression (as told by a doctor of health professional): Maryland BRFSS (http://www.marylandbrfss.org/cgi-bin/broker.exe); Adults with Chronic Drinking (more than 2 per day for males, 1 per day for females): Maryland BRFSS (http://www.marylandbrfss.org/cgi-bin/broker.exe); Adults with Chronic Drinking (more than 2 per day for males, 1 per day for females): Maryland BRFSS (http://www.marylandbrfss.org/cgi-bin/broker.exe).*

JURISDICTION	Population Over 15 with Substance Issue	ADAA Public System Treated, FY 2014	SED Estimate	SMI Estimate	Adults Diagnosed with Anxiety	Adults Diagnosed with Depression	Adults with Chronic Drinking
Allegany	3,592	2,664	974	3,128	21.9%	18.3%	6.6%
Anne Arundel	15,915	8,138	8,376	22,456	17.6%	15.2%	7.5%
Baltimore City	33,405	40,108	8,622	25,522	15.9%	18.5%	6.1%
Baltimore County	29,572	15,964	12,091	33,596	15.5%	16.6%	4.5%
Calvert	2,459	2,230	1,570	3,557	15.0%	15.5%	7.2%
Caroline	1,441	843	525	1,303	12.5%	18.0%	3.1%
Carroll	4,099	3,026	2,780	6,728	20.1%	22.0%	8.9%
Cecil	3,595	3,729	1,646	4,069	16.7%	18.9%	4.4%
Charles	4,356	2,412	2,671	5,952	12.2%	10.4%	3.8%
Dorchester	1,662	1,255	445	1,357	12.2%	15.5%	5.0%
Frederick	6,406	3,394	4,023	9,538	15.7%	15.6%	5.0%
Garrett	1,411	438	427	1,249	22.1%	17.6%	4.4%
Harford	7,157	4,740	4,006	9,995	13.3%	18.8%	5.0%
Howard	5,422	2,336	5,210	11,953	13.8%	19.3%	4.3%
Kent	824	1,014	265	849	15.6%	22.1%	9.7%
Montgomery	21,814	5,112	15,700	40,733	11.2%	14.7%	5.2%
Prince George's	30,330	6,851	13,687	35,616	7.2%	11.4%	3.8%
Queen Anne's	1,307	987	754	1,967	13.7%	13.7%	6.6%
St. Mary's	3,229	2,107	1,866	4,263	13.4%	15.3%	3.6%
Somerset	1,423	1,351	359	1,105	11.4%	11.7%	2.2%
Talbot	1,434	1,081	482	1,628	13.6%	15.0%	5.4%
Washington	6,515	4,515	2,236	6,104	22.0%	26.9%	3.3%
Wicomico	4,666	3,344	1,676	3,984	10.9%	14.0%	7.1%
Worcester	2,151	1,534	632	2,235	10.6%	15.1%	5.5%
Maryland Total	**194,185**	**119,173**	**91,023**	**238,887**	**13.8%**	**15.9%**	**5.2%**

The State is considering several areas for CCBHCs, including the metropolitan Baltimore area. While Baltimore City has relatively complete crisis system services for adults and children, along with a large number of behavioral health service providers, problems of homelessness, hospitalization, and incarceration are still very evident in the area.

At least one CCBHC will be established in a rural area, such as Garrett County in Western Maryland and Worchester County on the Eastern Shore. No rural area has a complete array of crisis services, resulting in overutilization of emergency department (ED) and inpatient services. Few rural areas have access to evidence-based practices. Behavioral health professionals, especially psychiatrists, are difficult to recruit in these areas. Transportation is also a major issue, and the cost of providing transportation erodes the funding available for services.

A.3:

Table 3 summarizes the capacity of Maryland's current Medicaid State Plan to provide the services in Appendix II, Section 4, "Scope of Services," which defines the services as listed in criteria 4.B through 4.K. Many CCBHC required services are covered by Medicaid.

Table 3: Maryland Medicaid State Plan Capacity to Provide CCBHC Services

Service (Criteria)	Maryland Medicaid State Plan Capacity to Provide CCBHC Services
Person-Centered and Family-Centered Care (4.B)	With the exception of the State Plan 1915(i) for children with SED, language regarding family-centered, recovery-oriented care is not included in the State Plan. State regulations require outpatient mental health centers to be age and culturally appropriate, focused on recovery and resiliency, address individual needs, strengths, recovery, and treatment expectations and responsibilities, and to describe how the needed and desired treatment will help the individual manage his or her psychiatric disorder and to support recovery.
Crisis Behavioral Health Services (4.C)	The State Plan requires that Mobile Treatment and ACT be available, if needed, 24/7. State regulations require outpatient mental health centers to have 24/7 on-call and crisis intervention services.
Screening, Assessment, and Diagnosis (4.D)	Maryland's State Plan references our Medicaid fee schedule, which includes a rich array of screening, assessment, and diagnosis services. State regulations also describe screening and assessment requirements in detail.
Person-Centered and Family-Centered Treatment Planning (4.E)	The State Plan allows for Medicaid reimbursement for treatment planning by a licensed mental health professionals in the presence of the Medicaid enrollee at a hospital outpatient department, outpatient mental health center, and FQHC. State regulations also describe the evaluation and treatment planning processes.
Outpatient Mental Health and Substance Use Services (4.F)	The outpatient mental health center section of the Maryland State Plan includes a broad statement regarding comprehensive coverage of outpatient mental health services, including traditional outpatient, intensive outpatient, and partial hospitalization services. Maryland regulations include requirements for comprehensive evaluation, individual treatment plans, and services including mental health treatment and co-occurring SUD treatment. Currently under review by CMS, the State Plan is being rewritten to move all SUD programs under one section. The services include assessment; level 1 group, individual and family therapy; level 2 intensive outpatient therapy; partial hospitalization; opioid maintenance; and inpatient and ambulatory detox.
Outpatient Clinic Primary Care Screening and Monitoring (4.G)	Maryland's State Plan references our Medicaid fee schedule, which includes screening, monitoring, and preventive interventions for children. Maryland also has a Health Home 3.1F program which targets individuals who receive services through psychiatric rehabilitation programs and opioid treatment programs.
Targeted Case Management (4.H)	Targeted case management for adults with SMI and children with SED are included in the State Plan
Psychiatric Rehabilitation Services (4.I)	Psychiatric rehabilitation services are included in the State Plan in 3.1A, pages 29C-13 to 29C-18, in 4.19 A&B, pages 63 -- 63a.
Peer Supports, Peer Counseling and Family/ Caregiver Supports (4.J)	Peer supports and peer counseling are not included the State Plan. Functional family therapy is currently included for children eligible for 1915(i) home and community based services.
Intensive, Community-Based Mental Health Care for Members of the Armed Forces and Veterans (4.K)	All State Plan services are open to Medicaid eligible members of the U.S. Armed Forces and veterans.

A.4:

Service Gaps

In recent years, Maryland's behavioral health delivery system has become more recovery-focused and person-centered. DHMH has also advanced regulatory reforms moving away from discrete program types, each with separate regulatory standards, to a model in which national accreditation plays a major role in licensing providers. Despite the availability of Medicaid funding for many services, DHMH recognizes service gaps remain that inhibit the ability of Marylanders with serious behavioral health challenges to access the comprehensive, coordinated quality care they need to maintain their overall health. Part of the problem stems from providers who still operate separate programs for SUD and mental health. Other service gaps include:

- **Supported Employment and ACT:** Services are limited to certain geographical areas and supply has never been sufficient to meet demand.
- **Targeted Mental Health Case Management**: While Targeted Mental Health Case Management (TCM) is available in all jurisdictions, it is underused. There is a lack of general case management services for those many individuals who need some guidance and coordination but who do not require the intensity of a Targeted Case Management service.
- **Medication Assisted Treatment**: MAT is an EBP known to be effective for individuals with opioid addictions. Maryland has established MAT programs across the state, but this essential SUD service is underutilized—in part due to stigma. Many individuals with SUD do not consider medication an appropriate path to recovery. CCBHCs will work to eradicate the stigma surrounding MAT and enroll those who are in need into this valuable service. As an adjunct to MAT services, Maryland will establish peer operated Medication Assisted Recovery Services (MARS) into the MATs in CCBHC service areas through a contract with Maryland's statewide consumer organization as described in subsequent sections.
- **Peer and Family/Caregiver Support**: These services are not covered by Medicaid with the exception of the Section 1915(i) State Plan Amendment services for children and youth. This new program provides specialized services for children and families who meet eligibility criteria and is accompanied by a new separate TCM program specialized for children and families. Providing these peer and caregiver support services in a CCBHC, through Medicaid, will broaden the availability of these services in the community and improve individual and family recovery. Maryland's strong consumer and peer network will provide an excellent base of peer and family support services for CCBHCs.

Need

The initiative's target population has a significant need for a CCBHC model of care delivery. Nearly one person in five is eligible for Medicaid; however, coordination of services within the public behavioral health system and across providers and systems of care is not sufficient. At a statewide level, the penetration rate for PBHS services is 13.8%. Of the four MD counties whose eligible Medicaid population exceeds 148,000, the penetration rate is 8.4 and 7.3% respectively.

Hospital utilization rates for behavioral health conditions are a major concern statewide. A cohort of individuals with severe and persistent behavioral health issues resist engagement or ongoing treatment in services and consequently over utilize both ED and/or inpatient services. Based on SAMHSA URS data, Maryland's rate of community hospital utilization for behavioral health conditions (1.64 per 1,000 population) is 18% above the national rate. Nearly 7.5% of

public behavioral health system consumers are hospitalized in a given year. For those who were in service at an outpatient clinic, 8% were hospitalized in FY11 while 9.5% were hospitalized in FY15. In addition, the 30-day readmission rate to community hospitals for such stays is currently 22%. The high readmission rate following discharge from a psychiatric stay strongly suggests that issues of coordination of care exist between inpatient and outpatient settings. Services offered through CCBHCs, including increased care coordination, the availability of residential crisis services and strong peer support, should have a positive effect on these rates.

In its annual Consumer Perception of Care surveys, Maryland's adult consumers consistently rank all domains of health care service (access, quality, outcomes, and general satisfaction) below national levels. Results of the Child and Adolescent surveys are better, although access, satisfaction, and outcomes are below national levels. In conjunction with a separate effort, in FY12 Maryland studied 500 of its most intense and least connected adult clients, identified based on their mental health inpatient expenditures exceeding the 80th percentile of inpatient expenditures and/or their use of EDs for mental health issues six or more times during the year. The individuals with at least six ED visits accounted for one in four ED visits; most clients (over 70%) who use EDs did so only once during the year. Nearly 200 of the consumers identified in FY 12 remained in the cohort the following year, indicating that this is a difficult to engage group. The overwhelming majority of the cohort, nearly 75%, also had a SUD diagnosis during the year. These individuals will most likely realize a great benefit from the CCBHC model.

Employment for those with behavioral health issues is a major concern. Eliminating those who do not consider themselves in the workforce, only 38% of adults receiving services in the public behavioral health system are employed. CCBHCs will include expanded use of EBP-supported employment services. Among clients active in EBP-supported employment services, the employment rate is just below 50 percent. While still less than optimal, increased use of EBP-supported employment services should improve quality of life and service outcomes for many clients. Also, based on survey results, less than one quarter of Maryland's public behavioral health system clients have participated in Wellness Action and Recovery Plan services or in family support activities. CCBHCs will expand the availability of and access to these services.

SECTION B: PROPOSED APPROACH

B.1:

Maryland's behavioral health delivery system has made significant strides in recent years to become more recovery-focused and person-centered. DHMH has instituted regulatory reform, provided financial support for a wide range of enhanced services, invested in the diversification of staffing, and offered broad workforce training in motivational interviewing and trauma-informed care. Maryland's goal has been to align incentives, oversight, payments and staff competencies to enhance the quality, accessibility and coordination of our service system. Despite these advances, gaps remain that inhibit the ability of Marylanders with behavioral health challenges to access the comprehensive, coordinated quality care that they need. By implementing CCBHCs, we will be able to further enhance the quality, organization and overall capacity of our service system. The major improvements we anticipate as a result of the establishment of CCBHCs are:

Expanded and enhanced care coordination, including expanded peer-driven care navigation: While all Maryland jurisdictions have some mental health case management services for adults and children, the CCBHC initiative will enable the expansion and improved integration of formal case management and care coordination for people with both mental illnesses and SUDs. Further, the initiative will ensure these case management services leverage formal partnerships with medical care and social services resources in Maryland, including our 15 FQHCs (five rural), inpatient facilities, Department of Veterans Affairs (VA) facilities, Tricare, and other social services. In addition, care coordination services will be enhanced by assurance of fidelity to person and family-centered care plans.

Beyond traditional 'professional' case management, peer and family support services will be partners in the expansion of these coordination services. The unique perspective of those with lived experience will be essential not only in furthering care coordination, but also in expanding outreach and engagement services. Maryland has experience in using peers to meet with clients who present in EDs or are admitted to inpatient detox as a result of an overdose. The peers work to engage the clients in SUD treatment, especially opioid replacement therapy, which enhances both initial engagement and ongoing participation in therapy. Maryland will leverage CCBHCs to expand this effort, using trained mental health peers as care coordinators and in ED and inpatient settings to work with those with mental health issues.

Improved peer and family support: We will leverage the CCBHC initiative to provide technical assistance to improve the quality of peer and family support by using the expertise developed in Maryland's Statewide Consumer organization On Our Own (OOO) of Maryland and the statewide family network, the Maryland Coalition of Families for Children's Behavioral Health (MCF). These organizations lead a successful joint project that provides outreach, support, and leadership for young adults in the transition period between the adult and adolescent service sectors. Their shared roles and responsibilities on this project are unique nationally for their collaborative impact. Both organizations provide peer support statewide and have the capacity to work with CCBHCs to provide technical assistance and training on innovative approaches in the provision of peer and caregiver support, diversifying and supporting a peer workforce, and conducting outreach to local affiliates. In addition, both organizations have strong network capacity for cultural competence and provide specialized support for LGBTQ groups and individuals.

Enhanced services for veterans, including veterans of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF): CCBHCs will also improve the integration of services for veterans into the community-based behavioral health service systems. In addition to linkages with VA facilities and Tricare, through Maryland's Commitment to Veterans, we will collaborate with CCBHC staff to educate them on military cultural competency training opportunities. The Veterans Choice Program is making it easier for thousands of veterans to receive their health care from providers outside of the VA system. Many community providers are not trained or experienced in treating veterans' unique needs. We will utilize a free online continuing education course developed by the VA and the Department of Defense (DoD), Military Culture: Core Competencies for Health Care Professionals, to ensure that all veterans in Maryland have access

to behavioral healthcare that is culturally appropriate, coordinated with their benefits and integrated into the service systems in the communities in which they live.[2]

Enriched linkages between the correctional behavioral health care system and the community-based system: Maryland currently operates a "data link" program with many local jails and state correctional facilities. Our ASO receives a daily feed of individuals arrested on the previous day from the Department of Public Safety and Correctional Services. The ASO provides a data feed to clinical staff of the local detention center or state correctional facility if the individual is in mental health treatment and/or on psychiatric medication. The mental health service provider is also notified by the CSA, the local mental health authority, of a client's arrest when possible and appropriate. This effort will be expanded to include SUD data once the necessary consents are built into the VO system. Maryland will also expand this effort to provide direct notice to CCBHCs once the necessary data sharing agreements and privacy protections are in place. This measure will support coordination of care between the criminal justice facility and CCBHCs.

Improved crisis support services and a more substantial crisis follow-up service: While Baltimore City has two strong crisis response and intervention systems, one for children and adolescents and another for adults, much of the rest of the state has more limited resources. Almost every county has established crisis intervention teams, though they are not necessarily all available 24/7. Additionally, nearly all counties offer short term, state-funded crisis respite beds as both an alternative to, and a step-down from, psychiatric inpatient services. Every county already has access to a 24/7 behavioral health crisis hotline and emergency department psychiatric services. The promising practices developed by the Baltimore City system will be incorporated in the technical assistance that will be provided to CCBHCs to ensure that 24 hour mobile crisis services, emergency crisis intervention and crisis stabilization are offered. This effort will also help us to prioritize the development of stronger crisis response, intervention, and follow-up stabilization services that utilize peer and family support.

More robust outreach and engagement of difficult to reach and difficult to engage populations: The expansions and enhancements of care coordination that are elemental to the CCBHC implementation process will enable Maryland's service system to more effectively reach out to individuals and families who have either not engaged with the system or are utilizing only emergency room services. By expanding the availability of care coordinators and peers of all ages who can follow-up after hospitalizations, detentions, and out-of-home placements, we will improve connection and engagement with the behavioral health service system. DHMH will also train CCBHC clinicians and care coordinators in techniques known to facilitate client engagement for particularly difficult to reach populations (e.g. young adults) and to encourage ongoing fully engaged participation in treatment and support services.

Better, and more consistently trained staff, which will lead to an improved experience of care for our clients: All areas of the State are served by one or more Psychiatric Rehabilitation Program (PRP) providers; many have access to either mobile treatment or ACT services as well as supported employment services, some of which meet fidelity. As part of implementation, we will identify instances in which CCBHC services are being provided without fidelity to the

[2] http://deploymentpsych.org/online-courses/military-culture.

existing evidence base. In those instances, we will offer training and technical assistance to enable the CCBHC to achieve fidelity, thus expanding the capacity of our service system to provide evidence-based treatment. Additionally, as indicated in B5, DHMH will train treatment staff at CCBHCs as needed to ensure that each has the capability to offer a set of evidence-based treatment interventions, including Person-Centered Care Planning (PCCP), Trauma Informed Care (TIC), Motivational Interviewing (MI), Cognitive Behavioral Therapy (CBT) and Dialectical Behavioral Therapy (DBT) and cultural competence training regarding military/veterans, LGBTQ and youth.

A more diverse workforce, including more staff with lived experience: Established over 20 years ago, Maryland's Cultural Competence Advisory Committee worked with researchers to develop a cultural competence tool and committee members have trained many Maryland providers. The cultural competence effort will be expanded into CCBHCs in concert with the training provided by our statewide consumer and family organizations. Each CCBHC will be evaluated through the lens of the specific identified needs of ethnic and cultural minorities within their service communities and a site-specific plan will be developed.

B.2:
DHMH has a long history of involving behavioral health consumers, family members, advocacy organizations, providers, local governmental agencies, our state partners, academics and other stakeholders in all aspects of planning, policy development, decision-making, and service implementation. In Maryland, it is common practice to have all stakeholders provide input into systems improvement activities.

In July 2014, Maryland's Mental Hygiene Administration merged with the Alcohol and Drug Abuse Administration to form BHA. At that point, the legislature replaced existing mandated advisory councils with the Behavioral Health Advisory Council, which is statutorily empowered under Code of Maryland Statute Article – Health – General Section 10–101 to participate in behavioral health service system planning, policy, workforce development, and services to ensure a coordinated system of care that is outcome driven and integrates prevention, recovery, cultural competence, evidence-based practices, and cost effective strategies to enhance behavioral health services across the State. We have asked them to provide input on the development of this program and we will provide them with updates on implementation progress during the planning and demonstration grant periods.

During Maryland's behavioral health integration process, the State had over 700 individuals and organizations who provided input into the process. To best serve our community, a listserv was established to inform and solicit comments from stakeholders. We have used this listserv to solicit input into this application and intend to continue during the planning and demonstration grant periods to engage stakeholders, distribute information, and receive feedback.

We will also utilize the Maryland Medicaid Advisory Committee (MMAC) to obtain stakeholder input. MMAC consists of 28 members, including consumers and advocates for the Medicaid population; senators and delegates from the Maryland General Assembly; providers who are familiar with the medical needs of low-income population groups; hospital representatives; representatives of the Maryland Health Care Commission, and the Maryland Association of

County Health Officers. We presented this application to MMAC at their July 23, 2015 meeting and will provide regular updates throughout the planning and demonstration grant periods.

BHA and Medicaid also co-chair a monthly Provider Council meeting involving representatives from the ASO as well as providers of behavioral health services. This meeting is an opportunity to share information with providers and allows providers to ask questions and offer input on system development and service delivery. We will use the Council to engage the provider community during the grant period.
In addition, Medicaid and BHA have an established relationship with Native American Lifelines (NAL), an urban Indian Health Service with locations in Baltimore and Boston. NAL provides behavioral health treatment, case management, dental care, prison outreach, and other preventive and supportive services to the American Indian community through a comprehensive continuum of care that is patient centered, culturally sensitive, and optimal for personal growth. NAL Board member Kerry Hawk Lessard serves on the MMAC. In addition, throughout the planning grant and demonstration grant periods we will consult with the Maryland Commission on Indian Affairs, a gubernatorial-appointed State advisory board, about which urban Indian organizations and other tribal organizations in Maryland we should involve in this effort.

B.3:
Maryland will select up to five providers to certify as CCBHCs. Our priorities for selecting providers will be their readiness to provide the comprehensive, coordinated services required, the quality of the services they provide, the need of the community they serve and a geographic spread that enables us to demonstrate the efficacy of CCBHCs in urban and rural areas.

The first step in the application process will require that the provider show that they meet three threshold criteria: (1) The applicant is currently providing all four required CCBHC basic services;[3] (2) Accreditation by either the Commission on Accreditation of Rehabilitation Facilities (CARF) or The Joint Commission (TJC); and (3) Active, sophisticated EHR and accounting systems that are sufficient to enable the data collection and reporting that will be required for planning, evaluation and ongoing quality improvement. We are aware that there may not be any rural providers that are able to achieve all three of these thresholds. If that is the case, we will choose among the best of the rural providers and provide extra technical assistance to help them achieve the required thresholds over time.

Our application process will contain elements that enable DHMH to ascertain which potential providers meet our established priorities. We will require data about the needs of the communities they serve, information about the results of both programmatic and fiscal audits conducted by the state and their readiness to be certified as a CCBHC. In order to do the latter, we will use the CCBHC Certification Criteria Readiness Assessment Tool (CCRAT) created by MTM Services in collaboration with the National Council for Behavioral Health.

[3] Given the brevity of the planning grant period, we do not believe it is possible to develop new services in time to achieve certification during the planning grant; therefore, we have established this as a threshold criterion for any potential participating provider

Based on these applications we will select up to eight geographically diverse semi-finalist candidates for potential certification, with at least one each urban and rural provider. Candidates will then be asked to demonstrate (e.g., producing letters of commitment, draft memoranda of understanding between the applicant and any DCOs, etc.) their ability to provide the nine required services either directly or through agreement. Based on the CCRAT score, the quality of plans for the provision of all necessary services, providers' ability to provide EBPs with fidelity to the model, community needs, providers' data collection and reporting processes, and geographic diversity, the DHMH will select two to five providers as the final candidates for CCBHC program certification with at least one each in an urban and rural area.

After the candidate providers are selected, the State and its technical assistance team will create a custom technical assistance plan for each organization to help them meet the programmatic requirements of the CCBHC model. During the planning period the State will identify the full scope of technical assistance needs that will emerge among applicants. For those issues that are common among all applicants, we will establish collaborative learning opportunities so that we can maximize technical assistance resources.

Similarly, when needed, we will collaborate with our colleagues in both State and local governments to broker and refine relationships with other social service sectors (e.g., schools, child welfare agencies, foster care provider, etc.) in areas such as establishing agreements. The technical assistance component of this initiative will constitute a major portion of activity and will be refined throughout the planning grant period as we learn more from our stakeholders.

B.4:

Maryland has requirements already in place that have positioned us to implement CCHBCs rapidly, efficiently and effectively. By the time the planning grants are awarded, all Medicaid-funded behavioral health service providers in Maryland will be required to be accredited by either TJC or CARF. As such, these agencies will have grievance procedures and CQI processes and will be required to provide services that recognize and respect the cultural norms and traditions of the populations that they serve. Similarly, all treatment personnel in outpatient mental health centers (OMHC) are currently required to be licensed mental health professionals and many also include licensed addiction professionals. CCBHC candidates are already required to ensure that all services, including those provided by DCOs, meet the requirements of Section 2402(a) of the Affordable Care Act—that services are person and family-centered, recovery oriented, and reflective of clients' needs, preferences, and values, and that services for youth are family-centered, youth-guided, and developmentally appropriate.

As a result of the manner in which behavioral health services have developed in Maryland, and dependent upon which providers receive CCBHC certification, we anticipate some variation in the implementation of the program; however many elements of the CCBHC implementation will be consistent. All CCBHCs will provide traditional outpatient behavioral health services, including screening, assessment, diagnosis, patient-centered treatment planning, outpatient behavioral health services, and care monitoring and coordination as well as intensive, community-based outpatient behavioral health services for members of the US Armed Forces and veterans. Most OMHCs currently offer a majority of these services and the extent to which they are offered in a high quality, culturally sensitive way will be assessed as part of the CCBHC

application process. Should gaps exist DHMH will offer a robust package of training and technical assistance to CCBHCs working toward certification in programmatic areas as needed.

While CCBHCs will offer to provide care coordination to all participants, individuals with unique needs beyond the general capacity of the CCBHC will be referred to existing Targeted Mental Health Case Management (MHCM) providers for both children and adults with whom the CCBHC will establish a DCO agreement. In those cases, the CCBHC staff will work closely with the MHCM staff to assure that appropriate coordination is occurring.

Psychiatric rehabilitation program (PRP) services will rely on established local providers, including the CCBHC or a partner with whom the CCBHC will establish a DCO agreement. It should be noted that given existing referral patterns and systemic relationships in Maryland, agencies entering into DCO relationships are likely already collaborating and sharing clients.

We anticipate that CCBHCs will establish DCO agreements with existing local peer-operated wellness and recovery centers, OOO and MCF to provide peer and family support services and Wellness Recovery Action Planning.

In addition to required services, there are a large number of services funded by the public behavioral health system that will be available to CCBHC clients, including Residential Rehabilitation Programs (RRP), Psychiatric Rehabilitation, Targeted Case Management, Mobile Treatment, Supported Living, Supported Employment, Residential Crisis, Behavioral Health-Related Laboratory Services, Permanent Supportive Housing, Residential Substance Use Treatment Services, Substance Use Recovery Support Services, Respite care for children and youth, Maryland RecoveryNet care coordination, Therapeutic Behavioral Services (TBS) for children and youth, Supportive Transitional Housing (Recovery Housing), Continuing Care, Recovery Community Centers (RCC) and Recovery Coaching.

B.5:
BHA has a long history of using EBPs to transform the behavioral health system and to support recovery for individuals diagnosed with mental illness, SUDs, and co-occurring disorders. The former Mental Hygiene Administration (now BHA) was one of the first state mental health authorities in the country to recognize the promise offered by the EBP movement to positively impact the quality and delivery of mental health services. BHA created the Behavioral Health Systems Improvement Collaborative (BHSIP) at the University of Maryland Division of Psychiatric Services Research (DPRS) that includes the Evidence-Based Practice Center (EBPC), the Training Collaborative (TC), and the Systems Evaluation Center (SEC).

Partnering with the BHSIP, BHA has a two-pronged approach to the implementation and monitoring of EBPs. The EBPC offers training and technical assistance to providers as they plan and prepare to implement a given EBP, and the BHA maintains a staff of fidelity monitors on the FMT who visit and assess each agency offering an EBP. In the first years of implementation, the SEC evaluated the effects of EBP implementation. Both as an incentive to offer EBPs and to defray the extra costs associated with the provision of the EBP service, the BHA offers enhanced rates to providers meeting and maintaining fidelity for these services.

The effectiveness of CCBHCs for the focus population is rooted in the adoption of system of care principles that support SAMHSA's four dimensions of recovery–Health, Home, Purpose, and Community. Maryland proposes using multiple EBPs based on individual needs to ensure individually driven successful long term outcomes. These will include the set of EBPs currently in use as well as some additional practices. All CCBHCs will be required to demonstrate fidelity—as certified by the FMT—to a core set of EBPs. We have preliminarily selected: ACT, Supported Employment, Functional Family Therapy, and Medication Assisted Therapy. These four EBPs can have a profound impact on the lives of people throughout the lifecycle with serious behavioral health disorders and their families—and their congruence with SAMHSA's four dimensions of recovery. In addition, when taken together these four EBPs create a coherent service continuum that engages someone in treatment, facilitates the development of their support network, and enables them to take ownership of their recovery.

ACT is an essential component for individuals with severe and persistent mental illness—a major population of focus for CCBHCs—who are unable to engage effectively in traditional treatment and support settings. By bringing a range of services and supports to the individual, the treatment team is usually able to maintain the individual's stability, and often move them into permanent housing, which is often a critical step in reengaging the individual in traditional treatment settings.

Evidence based **Supported Employment** is extremely effective in getting individuals with disabilities into the workforce. Employment is one of the pillars of recovery, and one of the main desires our clients express as they initiate their road to recovery.

Functional Family Therapy provides strategies to families with children experiencing emotional disturbance that facilitates the alteration of family dynamics to provide maximum assistance and to identify and limit triggering behaviors by both the family members and the child. It is based on CQI like techniques and is currently offered to children eligible for the 1915(i) SPA services.

Medication Assisted Therapy is the use of methadone, buprenorphine and related drugs in conjunction with SRD treatment services to replace opioids that are being abused. It is highly effective in allowing individuals with an opioid addiction into a path of recovery that is generally much easier than complete abstinence from the opioid. Many individuals with serious, persistent SRDs are able to live very normal lives while taking the opioid replacement drugs in combination with a regimen of SRD treatment and recovery support services.

In addition to the required EBPs, applicants for CCBHC status who can demonstrate fidelity to EBPs that are recommended, but not required, will be treated preferentially in the application process. The following EBPs have been preliminarily selected because of their value to people with serious behavioral health challenges. Because of their as yet insufficient spread in Maryland, we are recommending, but not requiring them for providers pursuing CCBHC status.

Family Psychoeducation facilitates the recovery process by enhancing the understanding of both the client and the significant people in the client's life about mental health issues and mental

health treatment, and provides strategies to the client and significant others for improved understanding of, coping with, and altering unusual, maladaptive behavior patterns.

Early intervention with **First Episode of Psychosis Services** (FEPS) has been shown to slow or limit the debilitating effects of severe mental illness. FEPS is currently available in only three sites in Maryland, two in Baltimore City, where it is likely that at least one CCBHC will be established. While it is unlikely that this service will be available at the rural site, we will encourage all CCBHC applicants to either develop or access this critical intervention via a DCO.

WRAP is an EBP encompassing a self-management and recovery system designed to increase personal empowerment, improve quality of life, assist in setting and achieving goals, and decrease troublesome feelings and behaviors. OOO, a consumer-run organization, has embraced WRAP and has trained facilitators who can lead small groups through the process of developing an individualized plan to manage their illness. WRAP has been adapted and modified for individuals with serious mental illness and substance use disorders, families, and veterans. OOO will provide training and WRAP implementation support to all CCBHCs as a DCO.

MARS is a peer-facilitated recovery community for medication–assisted treatment (MAT) peers. The original project began at the Albert Einstein College of Medicine in Bronx, New York. Its success has led to the replication of the model across the United States and internationally. MARS is a complement to treatment that provides men and women in MAT programs the kind of peer support services that have traditionally only been available to the medication- free recovery community. OOO will provide training and leadership for implementation of MARS.

The **Adolescent Community Reinforcement Approach** (A-CRA) is a behavioral intervention that aims to replace structures supportive of drug and alcohol use with ones that promote a clean and healthy lifestyle. A-CRA has three different protocols and guidelines, depending upon the population it is serving, but the overall goals are to reduce substance use and dependence, increase social stability, improve physical and mental health, and improve life satisfaction.

During the planning period, DHMH will train treatment staff at CCBHCs as needed to ensure each has the capability to offer a set of evidence-based treatment interventions. The treatment modalities we will ensure are available at all CCBHCs are Trauma Informed Care (TIC), Motivational Interviewing (MI), Person-Centered Care Planning (PCCP), Cognitive Behavioral Therapy (CBT) and Dialectical Behavioral Therapy (DBT). These were selected because of the evidence base supporting them and because taken together they offer the most effective package of services for the broad range of disorders CCBHCs are expected to treat, and because stakeholder input indicates these are the treatment modalities our community wants access to. In addition, we will provide cultural competence training to all CCBHCs to ensure their ability to provide services that are linguistically and culturally sensitive, including for youth, members of the military and veterans, and the LGBTQ community.

- **TIC** is a clinical approach designed to address the consequences of trauma and facilitate healing. Because of the extensive prevalence of exposure to trauma in individuals with BH problems, training on TIC will be offered to all direct care service providers working in CCBHCs. TIC improves the clinical understanding of certain behaviors and offers

techniques to assist clients in understanding and overcoming barriers to recovery that trauma has caused.

- **MI** is a practice especially important in helping clients resolve any ambivalence they may feel about treatment that inhibits their ability to change their behavior. MI has been shown to be effective for a broad range of mental and substance related disorders, including alcohol and drug use and has been shown to significantly improve treatment adherence. CCBHCs will be encouraged to utilize MI in initial intake and orientation sessions as a means of improving engagement and adherence from the very start of treatment.
- **PCCP** is a manualized provider-based intervention that maximizes consumer choice for adults receiving mental health services. PCCP focuses on engagement and individualized care, thereby enhancing the impact of existing evidence based practices.
- **CBT** refers to a class of interventions that share the basic premise that mental disorders and psychological distress are maintained by cognitive factors. The foundation of this treatment approach maintains that maladaptive cognitions contribute to the maintenance of emotional distress and behavioral problems. Modern CBT refers to a family of interventions that combine a variety of cognitive, behavioral, and emotion-focused techniques. CBT has 2 critical components; Functional Analysis and Skills Training. Functional Analysis plays a critical role in helping the individual and counselor assess high risk situations that may trigger behavioral health problems. Skills Training (individualized) helps the individual unlearn old habits. With CBT, the overall goal of treatment is symptom reduction, improvement in functioning, and remission of the disorder. CBT protocols have been developed that specifically address various cognitive and behavioral conditions and have been found to be effective in the treatment of SUDs, depression, bipolar disorder, anger and aggression, criminal behaviors, general stress, and distress due to general medical conditions.
- **DBT** is a type of cognitive-behavior therapy that combines weekly individual therapy with weekly group skills training in mindfulness (i.e., awareness of present experiences), distress tolerance, emotion regulation, and interpersonal effectiveness over a period of at least 12 months. Between DBT therapy sessions, individuals complete homework assignments geared toward improving and reinforcing the new skills they learn. DBT is indicated for Borderline Personality Disorder, mental illness that is especially difficult to treat.

This package of EBPs and clinical treatment modalities will enable CCBHCs to provide high quality support to all of their clients across the life span.

B.6:
DHMH will leverage our existing monitoring and certification infrastructure to certify at least two, and up to five, CCBHCs before the end of the planning period. The certification process will be overseen by BHA and HCF. All CCBHCs will be required to be licensed as an OMHC under existing Maryland laws and to be accredited by either the Joint Commission or CARF. CCBHC financial certification will be conducted under the auspices of HCF.

Certification audits will be conducted by the ASO's existing audit staff in conjunction with BHA/HCF, the EBPC, the Child and Adolescent Center for Innovation and the Mental Health

Association of Maryland's Consumer Quality Team, in collaboration with the CCBHC program director. We will enlist our partners from the University of Maryland to provide technical assistance to the CCBHC providers to facilitate their preparedness for certification. The certification and compliance assurance will be conducted by existing staff at the ASO, HCF and BHA. Historically, BHA has approached compliance as a CQI opportunity. Given the nature of the requirements, the thoroughness of the screening process, and the quality of the providers we intend to select, problems of compliance seem unlikely. However, BHA CCBHC monitors will work with the selected vendors immediately after selections are made to determine any potential failures to meet requirements. If any shortcomings are identified, the provider will be required to complete a corrective action plan within 15 days of notification and be provided a timeframe for its implementation. The compliance officer/technical assistant will work with the provider in the preparation and implementation of the plan. Only in cases of extreme failure of compliance with flagrant refusal to come into compliance would the certification of the CCBHC be revoked.

B.7:
DHMH expects to complete the planning grant year with between two and five certified CCBHCs and a robust demonstration program application. We will have provided technical assistance and training to ensure that a comprehensive, coordinated, consistent set of services are available in CCBHCs throughout the state. Prior to the conclusion of the planning grant period, DHMH will conduct a year end assessment of each CCBHC's capacity to maintain the established CCBHC standards after the planning grant period ends.

DHMH has extensive experience working with our provider community to develop the skills and capability needed to ensure compliance with new program models and regulatory requirements. When health homes were implemented in October 2013, we spent the year prior supporting providers with training and technical assistance to enable their success. The lessons we learned will be invaluable as we prepare CCBHCs for the transition to the demonstration phase. Additionally, because the majority of the activities during the planning grant period will be conducted by existing staff of DHMH and our partner agencies, their knowledge will be invaluable to support all necessary activities during the interval between the submission of the demonstration program application and the awarding of the demonstration program. This will enable us to do a seamless handoff to the ASO, BHA and HCF. EBPs will be monitored by EBPC. As such, we are confident Maryland will be able to efficiently and smoothly transition from the planning grant period to the demonstration period should SAMHSA select us.

B.8:
We propose to develop a payment system for CCBHCs following the Certified Clinic Prospective Payment System 1 (CC PPS-1) model. DHMH's ability to implement a CC PPS-1 rate is dependent upon the appropriation of State General Funds. We have selected CC PPS-1 in order to make it possible for as broad a range as possible of providers in Maryland, especially in the rural areas of the state, to pursue CCBHC designation. Both CC PPS-1 and CC PPS-2 require providers to bear some risk. CC PPS-2, however, requires providers to bear a greater risk (as it is essentially a monthly payment), which we feel would discourage a portion of the potential CCBHC applicants from participating. In order not to overly limit the pool of potential CCBHC applicants in Maryland, especially in rural parts of the state, we plan to implement CC PPS-1.

Maryland will leverage existing relationships with the Hilltop Institute at the University of Maryland, Baltimore County and Optumas as part of the process. Maryland's Medicaid program has maintained a relationship with Hilltop since 1994. Hilltop is a non-partisan organization that conducts research, analysis and evaluations of publicly funded healthcare. Hilltop provides a research analytics function, utilizing claim and encounter data to support our care management and program design efforts. An ongoing multi-million dollar agreement currently in place will ensure engaging Hilltop in this effort will be quick and seamless. Hilltop subcontracts with Optumas, a leading actuarial firm to support rate-setting for the state of Maryland.

Hilltop will collect and analyze cost and visit data from potential CCBHC providers to ascertain their costs during the planning grant year. These data will be used to establish a per diem cost that is reflective of each agency's historical costs, case mix, service portfolio and DCO-related expenses. Hilltop will retain the services of a certified public accounting firm to verify the accuracy of the cost data and allowable costs. Optumas will support these efforts by verifying the quality of the data provided and certifying the actuarial soundness of the methodology for calculating the per diem payment rates.

Maryland further proposes to provide quality bonus payment (QBP) for CCBHCs that achieve the required QBP core measures detailed in Appendix III of the RFA. Maryland has considerable experience developing QBPs for both providers and the Managed Care Organizations (MCO) that participate in the Maryland Medicaid HealthChoice program. For example in 2007, the State implemented its Quality Assessment Program for nursing facilities. Facilities are assessed a per diem rate for each day of service provided to non-Medicare residents. In fiscal year 2010, the State phased in a Pay-for-Performance (P4P) program funded by a portion of the quality assessment payments.[4] Stakeholders played a crucial role in the development of the P4P program and their perspective informed the measures used to assess facilities' performances. Maryland also operates a Value-Based Purchasing (VBP) Program for its HealthChoice MCOs.[5] Since the VBP Program's inception in 1999, Maryland has regularly solicited feedback from stakeholders, including MCOs, the Medicaid Advisory Committee, local health departments, and advocates, to inform changes to the program.

As with these earlier QBP initiatives, Maryland will implement the CC PPS-1 QBP after significant stakeholder input into the design and operations. We may propose additional quality measures for QBP, beyond the core measures but that decision will be reserved for after we solicit further stakeholder input and authorization from CMS.

B.9:
Maryland will use the one year planning period to establish CC PPS-1 in such a way as to fund CCBHC providers sufficiently to provide the high quality coordinated service envisioned by the CCBHC initiative. The funding will include incentives to produce outcomes of value to both the people they serve and the service system which is providing funding. It will be necessary to establish proper fiscal control and accounting procedures that will enable us to tie funding to allowable CCBHC expenses. Fortunately, Maryland has significant relevant experience and previously developed procedures as a result of our existing rate-setting activities such as all-

[4] COMAR 10.09.11-1—.11-6.
[5] COMAR 10.09.65.03.

payer payment rates for hospital services regulated under the Health Services Cost Review Commission and the Medicaid MCOs capitation payments paid under Maryland's HealthChoice Section 1115 waiver. DHMH, Hilltop and Optumas, will consult with those organizations during the planning grant period to determine the detailed fiscal and accounting requirements that will be necessary to implement CC PPS-1. Furthermore, BHA will promulgate record retention requirements specific to CCBHCs for the cost report package and source documentation (e.g., invoices, patient records, cancelled checks) that will enable us to audit effectively.

To calculate CC PPS-1, two points of data are needed from each CCBHC. First, we must know the total annual allowable CCBHC costs for the selected providers. To do this, we will collect detailed cost reports from the pilot CCBHCs. A uniform set of data will be collected related to costs during the planning grant period and will be supplemented with data related to the years prior to the planning grant. We will request these cost reports utilizing a common template and timeframe. Cost reports will collect provider information, direct costs for staff as well other variable costs, indirect overhead costs, costs excluded from the reimbursement system such as non-CCBHC services and non-Medicaid reimbursable costs such as uncompensated care. Documentation requirements and instructions for each element of the cost reports during the planning phase will be developed. After receiving cost reports, Hilltop will input the data into an analytical file for further analysis and an individualized rate simulation for each CCBHC.

The other data element needed to calculate CC PPS-1 for each CCBHC is the total number of CCBHC daily visits per year. For this data, we will rely on reports from CCBHCs of the total visits for all payers provided by the CCBHC during the same cost data collection period. We will conduct a quality assurance check of this data. Once data are secured, the relative costs for each applicant will be compared in order to make adjustments for known factors (e.g., Medicare allowable costs, differences in labor and capital costs, distribution of services among the nine listed CCBHC services). Adjustments will be made to CCBHC applicant costs to account for differences between currently offered services and those they must develop to fulfill CCBHC requirements. After necessary adjustments are made, we will—for each CCBHC—divide the allowable annual CCBHC-related costs by the total number of CCBHC daily visits per year in order to establish the CC PPS-1 base per diem rate for each CCBHC.

Once base rates are calculated, a QBP methodology for CCBHCs will be developed that meets the required baseline metrics and any additional metrics we select based on stakeholder input and authorization from CMS. In establishing any additional metrics we will endeavor to align with the goals of the all payer hospital waiver along with input from our stakeholder community. We will rely on Hilltop and its subcontractors to calculate the measures and support the reporting methodology needed to ascertain providers' achievement of the relevant metrics.

B.10:
DHMH, as a result of our broad-based and inclusive process, has identified a wide range of critical partners who have committed to making the CCBHC program a success. Letters of commitment from all of these organizations are included in the Supporting Documentation. The organizations that will be included as partners in this effort are:

- **CRISP** has established a system of real time alerts regarding hospitalizations and emergency room visits. This highly effective system is already a requirement for our health home program providers, and CRISP will play a similar role in the CCBHC program.
- **ValueOptions Maryland**, as the ASO for Maryland's public behavioral health services system will provide access to essential data and reporting that will improve care quality and coordination as well as assist with the calculation and implementation of the PPS rate.
- **Hilltop Institute** will collect and analyze cost data from potential CCBHC providers to ascertain their costs during the planning grant year in order to establish a per diem cost that is reflective of each agency's historical costs, case mix and service portfolio.
- **Mental Health Association of Maryland** will assist with audit and certification process via their Consumer Quality Team, which ensures that any oversight DHMH provides is informed by the voice of people with lived experience.
- **On Our Own of Maryland** will provide WRAP training and WRAP peer support groups and other peer support for all CCBHC applicants, including MARS, and will provide training and technical assistance in the provision of peer support, supporting a peer workforce, and assuring the meaningful participation of peers in governance.
- **Maryland Coalition of Families for Children's Mental Health** will work with CCBHCs to provide technical assistance and training on involving family members in CCBHC governance and provide family peer-to-peer support at select sites.
- **NAMI Maryland** will provide critical stakeholder input into DHMH's design and oversight processes and will assist CCBHCs in ensuring that family members of people with behavioral health challenges are represented in the governing boards of CCBHCs. NAMI will also provide various peer-led programs including NAMI Peer-to-Peer, NAMI Connections, relapse prevention, recovery education, NAMI Family to Family, NAMI Basics, and NAMI Homefront education courses.
- **Maryland Recovery Organization Connecting Communities** will provide peer recovery technical assistance and training to the CCBHCs and will be available to give stakeholder input throughout the program.
- **The University of Maryland School of Medicine**, Department of Psychiatry, including the Behavioral Health Improvement Collaborative (the Systems Evaluation Center, the Training Center, and the Evidence Based Practices Center) and the Division of Child and Adolescent Psychiatry (the Center for Mental Health Innovation, the Maryland Behavioral Health Integration in Pediatric Primary Care program, and the Center for School Mental Health) will support all of the activities DHMH will undertake to ensure fidelity to the identified EBPs and track collection of GPRAs.
- **Behavioral Health Advisory Council** will provide oversight of the entire CCBHC planning, implementation and certification process.
- **Maryland Medicaid Advisory Committee** will provide oversight of the PPS rate setting process and payment implementation.

In addition to the agencies listed above, we will rely on a broad group of stakeholders for input. Some of the organizations involved in the development of this application who will remain involved in the implementation process should we receive a grant have provided letters of commitment to remain engaged and involved in the initiative. These agencies include: Maryland Addiction Directors Council, Community Behavioral Health Association of Maryland, Maryland Department of Veterans Affairs, Maryland Association of Counties, Maryland Association of

Core Service Agencies, Maryland Local Addiction Authorities, Maryland Department of Public Safety and Correctional Services, Maryland Correctional Administrators Association, and Native American Lifelines.

B.11:
BHA has experience developing opportunities for meaningful input by consumers, persons in recovery across the life span, and their family members. We will ensure CCBHCs have robust mechanisms to provide these individuals with an opportunity for meaningful input into the strategic and operational direction of the CCBHCs through board governance and feedback.

Throughout the State, BHA provides funding to over 25 Mental Health Wellness and Recovery Centers and OOO, the statewide consumer organization (the second oldest in the country). These along with other consumer-run organizations are strong and respected stakeholders and advocates in their communities and can provide valuable input and participation in CCBHC operations. These centers can also serve as a rich source of potential Board members. In addition, BHA also funds the MCF, a statewide family organization for youth with emotional and SUDs. MCF provides a Family Leadership Institute, a multi-weekend training experience, to prepare family members to serve in governance and advisement roles throughout the system. A joint program of OOO and MCF focuses on youth and young adults, which also provides an in-depth young adult leadership training for prospective board members.

Based on our extensive capability, BHA and its statewide consumer and family organization partners can provide technical assistance (TA) to CCBHCs to recruit, train and retain consumer and family member Board members. This support will include identifying potential candidates provided through BHA's Office of Consumer Affairs (OCA). OCA will offer training programs for meaningful in-depth involvement, anti-stigma, and cultural competency, an essential component for board cohesion. In addition to providing TA, BHA will work with Wellness and Recovery Centers by hosting listening circles comprised of consumers and family members to provide feedback to CCBHCs. BHA will also work with NAMI-MD to provide additional TA to CCBHCs. NAMI-MD offers peer-led programs including NAMI Peer-to-Peer and NAMI Connections, free education and support programs delivered by consumers for their peers in the community, as well as the NAMI Family-to-Family, NAMI Basics and NAMI Homefront education courses, for families, partners and friends of individuals with mental illness and the NAMI Family Support Group, all led by intensively trained family member peers. To verify that required governance criteria are being met, BHA will establish an audit standard for CCBHCs that ensures their compliance with Section 6.b. of the criteria for the demonstration program.

SECTION C: STAFF, MANAGEMENT, AND RELEVANT EXPERIENCE

C.1:
Maryland has extensive experience with similar projects and populations and has the capacity to manage and implement large-scale grants. The State has received numerous grants from SAMHSA and CMS in the adult, transition-aged youth, and child and adolescent arenas. These grants have supported Maryland in its development of a recovery oriented, consumer-driven, and culturally responsive behavioral health system. We have chosen to highlight a few of the relevant grants we have received over the past ten years.

- **SAMHSA System of Care grants.** In the child and adolescent arena, Maryland recently completed two SAMHSA System of Care grants (awarded in 2008 and 2009), one focused in Baltimore City (MD CARES) and the other in the nine rural counties of Maryland's Eastern Shore, (Rural CARES). In 2011 Maryland was awarded and is currently implementing another SAMHSA system of care grant, Project LIFT, which is designed to extend the specialized child services piloted in the initial demonstrations statewide. All three system of care grants were progenitors of the new 1915(i) State Plan Amendment (SPA), which is designed to sustain the efforts piloted by these grants and use a wraparound approach to coordinate care for youth with high intensity needs statewide.
- **SAMHSA Mental Health Transformation Incentive Grants (MHTSIG).** In 2005, Maryland was one of seven states to receive the first round of MHTSIG funding. Maryland used the grant to support policymakers, consumers, families, advocates, service providers, and the academic community to build a consumer-driven system that supports recovery and resilience across the lifespan. Through this five year grant, Maryland was able to implement and expand many recovery oriented initiatives including: Conversion of Consumer Drop-in Centers to Wellness and Recovery Centers, Evidence-Based Practices expansion, Trauma Informed Care, expansion of Consumer Quality Teams, Wellness Recovery Action Plan (WRAP), expansion of housing initiatives, and Mental Health First Aid. All of these changes have been sustained following expiration of the grant.
- **The Maryland RecoveryNet, an Access to Recovery SAMSHA grant.** Awarded in 2010, this grant was designed to link individuals being discharged from residential treatment to recovery support services in the community. Also included were inmates discharged from residential treatment programs within the correctional system and veterans leaving Maryland Department of Veterans Affairs treatment facilities. A total of 8,118 individuals were served over the life of the grant. After the grant ended, state funds were added to the BHA budget to ensure service continuity at a comparable level.
- **Screening, Brief Intervention, and Referral to Treatment (SBIRT) grant.** SBIRT is an evidence-based comprehensive, integrated public health approach to the delivery of providing screening, early intervention, and treatment services to patients at risk for substance use and mental health disorders. In 2014, the SBIRT grant was awarded to Maryland for five years and within that time, BHA is implementing and expanding SBIRT into 53 Community Primary Care Centers and two hospitals in 15 jurisdictions across Maryland with the expectation of screening at least 45,000 individuals.
- **SAMHSA Healthy Transitions grant.** In 2014 Maryland was the recipient of this five-year grant focusing on transition aged youth (TAY). As a result 70% of individuals enrolled in the program had achieved competitive employment within one year of enrollment
- **CMS "Alternatives to Psychiatric Residential Treatment Facilities" (PRTF) Demonstration project.** Maryland just completed this initiative which was designed to test the value of using specialized community services to reduce the use of institutional care. This was done using the 1915(c) waiver authority on a pilot basis Maryland is also a grantee in the CMS-funded Children's Health Insurance Program Reauthorization Act Quality Demonstration and is finishing up its sixth year implementing the only children's behavioral health project of several funded under this RFA.
- **Prescription Drug Monitoring Program (PDMP).** The development of the state-wide PDMP was funded by a series of federal grants. The purpose of PDMP is to collect and securely store information on drugs that contain controlled substances and are dispensed to

patients in Maryland. Through the resources of the PDMP, BHA is able to provide technical assistance and access to data for local jurisdictions' Overdose Fatality Review teams.

- **Medicaid Emergency Psychiatric Demonstration.** In State FY13, CMS approved Maryland's application for the Medicaid Emergency Psychiatric Demonstration, established under Section 2707 of the Affordable Care Act, to test whether Medicaid programs can support higher quality care at a lower total cost by reimbursing private psychiatric hospitals for certain services for which Medicaid reimbursement has historically been unavailable
- **Housing/homeless assistance.** BHA has been the recipient of several housing/homeless assistance grants for over 20 years. BHA has utilized funds from the Projects for Assistance in Transition from Homelessness (PATH) program and the Continuum of Care (formerly called Shelter Plus Care Housing Program) to provide housing, rental assistance and supportive services to individuals with mental illness and their families.

In addition, Maryland has extensive partnerships with key stakeholders who have experience in providing recovery-oriented and culturally appropriate/competent services. OOO, a statewide mental health consumer education and advocacy group that has over 25 years of experience in the State has partnered with BHA on many recovery oriented initiatives. Maryland's cabinet level Department of Disabilities is a resource and partner with BHA, and the state legislatively mandated Office of Minority Health and Health Disparities coordinates DHMH disparity reduction initiatives. Lastly, Maryland's Behavioral Risk Factor Surveillance System (BRFSS) monitors poor mental health days and utilization of mental health services for all populations.

C.2:

Maryland has assembled a highly qualified and seasoned project team in order to ensure that the CCBHC initiative will be developed and implemented successfully. All program staff contributions are in-kind. Key staff are noted by an asterisk (*). Position descriptions for key staff are included in Section E.

* **Albert Zachik, MD** – BHA Acting Executive Director: Principle Investigator (5%). Dr. Zachik received his BS in Natural Sciences from The Johns Hopkins University and MD from The Johns Hopkins University School of Medicine. He is on the Clinical Faculty in Psychiatry at the Johns Hopkins University, University of Maryland, and Georgetown University Schools of Medicine. He has over 33 years of experience as a Board Certified physician in Psychiatry and Child Psychiatry.

* **Daryl Plevy, J.D.** – BHA Deputy Director for Operations: Project Director (20%). Daryl Plevy has over 34 years of experience in local and State government. She has directed the legislative efforts of a United States Senator and advised a State of Maryland Governor on issues surrounding the Departments of Health and Mental Hygiene; Human Resources; Juvenile Justice; Education; Children, Youth and Families; and Public Safety and Corrections. She received her J.D. from the University Of Maryland School Of Law and her Bachelor of Arts in Sociology from the University of Maryland College Park.

* **Lisa Hadley, MD, JD** – Medical Director for the Maryland Behavioral Health Administration: Will assist in overseeing clinical issues (10%). Dr. Hadley has over 25 years clinical experience, providing and overseeing behavioral health services in a variety of settings, including a community mental health center, federally qualified health center, private group practice and

substance use disorder treatment program. Dr. Hadley has also 10 years' experience in Behavioral Healthcare managed care. She is board certified in General Psychiatry and she is certified to prescribe buprenorphine. She received her medical degree from University of Maryland School of Medicine. She received a B.S. from University of Maryland and a J.D. from University of Maryland School of Law.

*** Rebecca Frechard, MA, LCPC** – Chief, Division of Behavioral Health, DHMH Medicaid Office of Health Services: Will assist with policy and procedure development, systems review and implementation, and rate development (5%). Ms. Frechard has been the Chief for 3 years. Prior to this, she held the position of State Plan Lead which involved coordinating with high level staff, and performing as a liaison with CMS on updating and developing state plan amendments. Ms. Frechard also currently leads a division of Medicaid staff focused on policy development and implementation, including provider compliance activities, provider relations and enrollment into Medicaid.

*** Tricia Roddy, MSHA** – Director, DHMH Office of Planning: Will provide consultation and technical assistance regarding the development of the Perspective Payment System (5%). Tricia Roddy has been the Director of the Planning Administration at the Maryland Department of Health and Mental Hygiene for 11 years. Currently, Ms. Roddy plans and evaluates activities for the Maryland Medicaid program which has an annual budget of roughly $9 billion and provides access to health care services for more than 1.2 million people. She also serves as the Agreement Monitor for the Department's multi-year Master Agreement with the Hilltop Institute at the University of Maryland, Baltimore County. In previous roles, Ms. Roddy has held leadership positions in the Maryland Medicaid program, including Chief of Staff to the Medicaid Director and Deputy Director of Provider Management.

Gayle Jordan-Randolph, MD – Will assist in developing and leveraging partnerships with other State agencies and stakeholders (2%).

Marian Bland, LCSW-C – Will assist with insuring that all clinical services are accessible and meet the needs of the program population (5%).

Kathleen Rebbert-Franklin, LCSW-C – Will assist with ensuring that substance use disorder services are coordinated well (2%).

Thomas Merrick, M.A. – Will provide consultation and technical assistance related to child and adolescent services (20%).

Susan Tucker, MPH, MBA – Will assist with policy and procedure development, systems review and implementation, and rate development (5%).

Brandee Izquierdo, CPRS, RPS - Will provide consultation and technical assistance to CCBHCs regarding peer support services (5%).

Lisa Morrel, B.A., CAC-AD. - Will provide consultation and technical assistance for the implementation of A-CRA EBP (2%).

Jennifer Howes, LCSW-C – Will assist with program management (20%).

C.3:

Key people will include:

Dr. Albert Zachik- Principal Investigator. In his 33 years as a double board certified physician, he has served as the Principal Investigator on many successful grants. He is a nationally recognized expert on behavioral health services and is currently the Acting Director of

BHA. Dr. Zachik's career has been devoted to the development and oversight of public mental health and substance use services. He teaches evidence-based practices and other standards of practice to three major Schools of Medicine in the Baltimore/DC metropolitan area. Dr. Zachik has held various leadership roles in Maryland and with national organizations. He has worked for over 33 years with the Maryland's BHA in the development and oversight of public mental health and substance use services to children and adolescents, and now across the lifespan, with a special interest in the development of a quality system of care for those with mental health and substance use disorder needs.

Daryl Plevy- Project Director. Ms. Plevy was Principal Investigator on the successful transformation grant and has managed behavioral health services at both the state and local level. She is currently responsible for the overall operations of the BHA and has over 34 years of experience in local and State government; much of it devoted to the planning, development, and oversight of public BH services.

Dr. Lisa Hadley- Clinical Oversight. She has more than 25 years of experience in the clinical and medical management of direct practice behavioral health services and in managed behavioral health care settings.

Rebecca Frechard- Ms. Frechard developed the State of Maryland's Administrative Services Organization (ASO) Request for Proposal and is the contract monitor for the ASO that currently manages the behavioral health benefits of Maryland's Public Behavioral Health System. As the Behavioral Health Division Chief for Maryland Medicaid and the contract monitor for the State of Maryland's ASO, she is uniquely qualified to help integrate and coordinate the grant requirements between BHA, Medicaid, and the State's ASO.

Tricia Roddy- Ms. Roddy will provide oversight of rate setting with the Hilltop Institute and its subcontractors (Optumas and Myers & Stauffer). She has extensive experience with Hilltop in rate setting, developing risk-adjusted and capitated payment rates, as well as implementing prospective payment systems for Maryland's managed Medicaid program. Her role will facilitate the development of a prospective payment system for the CCBHCs, following the PPS-1 model.

This list of key staff have been involved with the development, implementation, and/or monitoring of several large-scale grants including the Mental Health Transformation grant, the Community Mental Health Services and Substance Abuse Prevention and Treatment block grants, Medicaid Emergency Psychiatric Demonstration, System of Care grants and Healthy Transitions grants. Many of these grants have been leveraged with Medicaid dollars, block grant and State general funds to develop Maryland's behavioral health service system.

SECTION D: DATA COLLECTION AND PERFORMANCE MEASUREMENT

D.1:
Having performed the evaluation for SAMHSA's Mental Health Transformation State Incentive Grant (MHT-SIG) for Maryland, the System Evaluation Center (SEC) has extensive experience

collecting the types of information required for GPRA reporting for the CCBHC planning grant. This will include identifying and reporting the number of organizations implementing training programs as a result of this grant, the number of people who are newly credentialed to provide behavioral health services consistent with the goals of the grant, the number of financing policy changes completed as a result of the grant, the number of communities that establish information technology links across multiple agencies to share service population and delivery data, the number and percentage of work group/advisory group/council members who are consumers and/or family members, and the number of policy changes completed as a result of the grant.

Maryland has developed the skills and experience needed to define, collect, and report such information. During its participation in the MHT-SIG evaluation, Maryland accurately and consistently collected this information from a wide range of agencies and stakeholders participating in Comprehensive Mental Health Plan (CMHP) activities. Many of the definitions and strategies that contributed to the successful collection of that GPRA data will also be used in the CCBHC evaluation. These include working with relevant state administrators, service agencies, and stakeholder groups to assess existing capacity to track such information; developing resources and providing technical assistance to ensure full reporting capability; maintaining ongoing communication to clarify data and ensure timely data collection; keeping detailed electronic records, both quantitative and qualitative, on each GPRA indicator; and submitting aggregated Maryland data, per indicator, into a SAMHSA online database.

During the planning grant, the SEC will be responsible for tracking and reporting GPRA data. Before and after selection of the CCBHCs, Maryland will have an open process with all stakeholders to solicit input and suggestions for design and implementation of the model. Once the CCBHCs are selected they will become part of a workgroup that will serve as a team along with interested stakeholders, state, and university partners to ensure smooth implementation, resolve any concerns, and enable rapid and continued progress on the GPRA measures. The SEC will report regularly to the group on GPRAs accomplished, those still outstanding and the progress of those in process. When needed, Maryland will establish subcommittees and workgroups in key areas to accomplish specific GPRAs or to overcome any identified barriers.

Maryland GPRA data will be reviewed regularly and used at the state level to identify infrastructure changes needed to support CCBHC implementation. Maryland will plan to put the GPRA data appropriate for discussion into a user friendly form for discussions with the CCBHC advisory boards as well as the MA, BHA, CSA, LAA, and CCBHC administrators. Maryland's only currently planned addition to the GPRA indicators will be a project management timeline, detailing deliverables and due dates which will be used to assure that the project progresses as necessary to assure a successful path to CCBHC implementation.

D.2:

During the planning grant year, Maryland plans to select CCBHCs who have sophisticated performance measurement infrastructure and continuous quality improvement processes in place. This will create a strong team at the provider level that can work with state and university experts, in addition to stakeholders, in designing and implementing model CCBHCs that can eventually be expanded statewide. When Maryland's Behavioral Health Homes were launched, providers were allowed to use a portion of their administrative funds to support EHRs and data

analytic software, and the providers played a key role in identifying and implementing the tools required for this purpose. Maryland proposes to build on the work started with Health Homes by using a similar model for CCBHCs as they are designed and launched.

As part of Maryland's Health Home initiative, many of the larger providers that currently have the capacity to become CCBHCs implemented ProAct, an analytic care management tool developed by Care Management Technologies (CMT) in collaboration with Missouri as an integral part of its Health Home Program. Maryland providers and ProAct continue to work to improve that system and they are also actively working to ensure that needed performance measures are in place should Maryland be selected as a demonstration state. These are generally the NQF-endorsed and may also be NCQA or HEDIS measures. Maryland will require that CCBHCs contract with CMT or a similar vendor of a data analytics tool.

In Maryland, this data analytics tool will function as the central point for performance measurement and population health management receiving data information from a variety of sources in addition to claims data. As an example, CMT currently receives a monthly feed of all Medicaid claims (medical and behavioral health) for individuals enrolled in Health Homes. Many of the items in Appendix A of the Criteria for the Demonstration Program to Establish CCBHCs are currently included in the ProAct analysis. Maryland intends to convene a workgroup to identify missing data elements and develop the appropriate workflows to expand the data collection process so that the vendor that is selected will be able to retrieve as much data as necessary from claims data, ASO data and individual EHR or manual data entry. Maryland will require the CCBHC's data analytic tool to have the capacity to analyze and report on all of the Appendix A items. CMT is currently in the process of working with some Health Homes to develop a level of interoperability that will allow electronic sharing of data between their EHRs and ProAct. This functionality will also be required of the CCBHCs and the selected vendor. Fortunately, all Maryland providers that have the capacity to become CCBHCs currently use a relatively small number of different EHRs, so the task of achieving interoperability is feasible. This way, the data necessary for most of the items in Appendix A can be retrieved by ProAct and can be analyzed (as opposed to just being collected and reported) and be used as a means of quality improvement (i.e. population health management) as well as for reporting and evaluation.

Additionally, CCBHCs will be required to have a certified EHR. Maryland understands that all of the necessary HIT enhancements are in the early stages, including building the capacity of a data analytics tool to report all of the required items, achieving interoperability between a data analytics tool and EHRs, and extracting information directly from EHRs. DHMH will work with selected CCBHCs either to assure that their various data analytic and EHR systems are capable of collecting and extracting needed data and information, to expand functionality to allow for these functions or to develop alternative data collection strategies.

Data for Mental Health Client Level Data and Treatment Episode Data Set, and certain Uniform Reporting System items are collected as part of the ASO authorization process. They are currently being used to make required reports to the Center for Behavioral Health Statistics and Quality of the Substance Abuse and Mental Health Services Administration. These data elements supply another rich source of client information; substance use programs will report admission and discharge information to allow assessment of treatment outcomes.

Because Maryland currently conducts a centralized, random sample telephone survey for its Consumer Perception of Care (MHSIP) surveys, Maryland will work with the selected vendor to implement a methodology for the collection of the survey data from CCBHC clients. This may depend, in part, on how these data are expected to be reported, whether at the individual question or the domain level. It is possible that the MHSIP items may be included in the EHR and presented for completion at appropriate times.

In addition to the items in Appendix A, each CCBHC will participate in the Outcome Measurement System (OMS) as part of its service authorization request. The OMS is a rich source of behavioral health/recovery data for clients ages 6 to 64. The OMS data is maintained in a datamart that allows the flexible analysis of outcomes data that includes measures of symptoms, functioning, recovery, living situation, employment, school performance, legal status, general health status, and tobacco use. A public model provides information at the state and county/CSA level. Providers and CSA administrators can also access their data aggregated to the level of service locations and across agencies. The BHA and SEC have provided a number of tools to assist providers in data interpretation, determination of statistical significance and effect sizes, and data utilization. Technical assistance has been offered to assist providers in using these tools for CQI activities. The OMS can provide significant information in the measurement of progress towards established CQI goals, especially in recovery oriented areas.

As previously mentioned, CCBHCs will be accredited by either TJC or CARF and will be required to have CQI processes in place. State technical support staff will provide additional technical assistance in this area and will sponsor joint learning communities and user groups among the CCBHC providers to facilitate the crafting and implementation of CQI initiatives. While CCBHCs will be free to establish their own priorities, there will be state targets for some CCBHC measures. Maryland will work with CCBHCs to establish learning communities to share experiences and successful strategies addressing common targets; to the extent that there are common local targets, the CCBHCs can also use this mechanism to address those as well.

D.3:
Maryland understands the importance of assessing progress during the grant period and is committed to reporting progress achieved, barriers encountered and efforts to overcome these barriers on a quarterly basis. In order to assure that the planning process achieves its goals, a timeline detailing deliverables and due dates will be established at the beginning of the project. Refinements will be made as necessary and appropriate as project personnel monitor progress.

Maryland has demonstrated the capacity to conduct such an assessment. During its participation in SAMHSA's Mental Health Transformation State Incentive Grant (MHT-SIG), Maryland was able not only to accurately and consistently collect information from a wide range of agencies and stakeholders participating in CMHP activities, but to use these data to inform the local evaluation. For example, under MHT-SIG, Maryland implemented town hall style meetings allowing all interested parties and stakeholders to participate in setting priorities, which were then used by providers to complete self-assessments which informed the development of a tailored technical assistance/consultation plan for each provider. Data was also collected to assist in a CQI process, which was especially helpful when there was a change in leadership at the

gubernatorial level because it allowed new leadership to be informed of prior progress in order to ensure that momentum forward continued. Today, years after MHT-SIG, local jurisdictions continue to report on efforts related to training that was started during the grant.

Many of these strategies will be used to report and assess CCBHC performance. Maryland GPRA data will be reviewed regularly by all state agency partners and stakeholders, and used at the state level as part of a CQI process to identify infrastructure changes needed to support CCBHC implementation and to identify any changes required to keep the planning and implementation project on time and on target.

Maryland will provide written quarterly reports within 15 days of the close of the reporting period, and will share that information with CCBHCs, DCOs and stakeholders. The report will detail the status for each deliverable due during the quarter, indicate the progress achieved, and identify any barriers encountered and efforts made to overcome them. Reports will also be shared with the CCBHC Advisory Committee and administrators from DHMH and other appropriate agencies. Once the pool of eligible CCBHC providers has been selected, administrators and boards or advisory committees as well as the local CSA and LAA administrators will be brought into the reporting and review process. As an important part of CQI, the State will share the reports with selected CCBHCs to allow each CCBHC to benchmark its outcomes against other CCBHCs. Maryland has experience in providing this type of data to stakeholders as it is currently providing quarterly benchmarking reports to its health homes.

D.4:
Maryland is committed to working with the national evaluation team on the design, data sources, and performance measures related to the evaluation. Maryland's successful experience with both Health Homes and the 1915i waiver have paved the way for a robust data collection and reporting infrastructure that will greatly aid the evaluation process. While Maryland is confident that the information for the national evaluation can be collected, there are, of course, some potential challenges, described below.

- Consumer and family support groups do not routinely bill independently and are likely to need assistance in providing data to CCBHCs. This can be addressed by asking those groups to establish within their DCO agreement appropriate HIPAA business associates agreements to allow access to CCBHC EHRs in order to input appropriate data into the CCBHC's billing system or establish a comparable process manually to permit the input of data into the system for purposes of billing and data collection. Since it will be necessary to establish data sharing agreements, HIPAA business associate agreements, and formal MOUs between CCBHCs and DCOs, template documents will be developed and finalized during the planning phase.
- The new reporting data related to physical health may be a challenge if the CCBHC selected from the rural area does not have an EHR, health home experience, or a physical health component in their existing service array. However, as noted in D2, Maryland will require that all CCBHCs utilize the same data analytics tool which will provide a vehicle not only for reporting purposes but also as a means of continuous quality improvement given that the data will be analyzed as opposed to merely being collected.
- A third challenge will involve the providers' requirement to operate data collection and reporting systems on top of the difficulties with developing a new service model and a new payment methodology. The state has extensive experience in providing technical assistance

to providers, including evidence-based practices and Health Home programming. The State will leverage this same expertise to provide consultation to providers regarding the data collection, analysis and reporting systems.

- A final challenge is to help providers continue to transition from using data only as a reporting function to utilizing the data as an integral part of their own internal continuous quality improvement systems. While many of the key providers that will seek to become CCBHCs have embraced this culture change, there is always room for improvement. One way to address this challenge is the requirement that all CBHCs utilize a common data analytics tool. However, the State will also provide on-going technical assistance in how to use these analyses even more effectively to improve internal systems in response.

D.5:
Maryland understands that they will be working with HHS and the evaluation planning team to construct the comparison group. Because of the wealth of behavioral health data that Maryland maintains, the selection of appropriate comparison groups should not present any significant problems. Initial thoughts are that comparison groups may be selected by pairing a non-CCBHC clinic with a CCBHC clinic based on general matching factors such as age, gender, race, ethnicity, behavioral health diagnoses, average symptom scores on the most recent OMS prior to project initiation, rural or urban location, and average behavioral health system costs per consumer. Appropriate weighting of selected individuals and/or propensity score matching based on clinic differences can be determined and applied.

Maryland's experience creating a comparison group for the Health Home evaluation will inform the construction of a CCBHC comparison group. While Health Homes focused on cost savings, the strategy will be equally effective when comparing access, quality and available scope of services between CCBHCs and non-CCBHCs. The CCBHC population and the traditional OMHC population will be matched, as closely as possible, on age, gender, ethnicity, race, diagnostic category and MA eligibility category. Should differences among providers be too great to find a near match, weighting will be carried out based on the observed rates of the particular characteristic in the CCBHC and traditional OMHC population. Alternately, each CCBHC client could be matched with a traditional OMHC client based on the aforementioned characteristics.

The State may also consider utilization and costs between the groups for emergency room utilization, hospitalizations, nursing facility admissions, and pharmacy utilization when creating comparison groups. This assessment may also be used to review each CCBHC independently for its overall costs and the allocation of its funds among services provided to inform future implementation and process modifications. The details of this process will be further refined during the planning year.

D.6:
For specialty behavioral health services, the ASO currently collects and processes authorization, claims, encounter, and outcome data, all of which are tied to a single consumer identifier. These data are used to produce MH-Client Level and URS Data for mental health services and TEDS data for substance use as well as for the production of a myriad of other reports. Encounter data will be collected either by the CCBHCs in conjunction with a DCO that is providing a service

that is not currently covered or by the submission of a zero pay claim directly into the ASO system. The ASO system will contain information on some state-funded services not reported to MMIS, so it may be a better source of most behavioral health data. Physical health information will come from MMIS claims and encounters as processed by Hilltop. Claims data are generally available within two days of their being processed. Authorization data are refreshed weekly. While OMS data is currently received monthly, a more ambitious schedule could be implemented if it were necessary. These data sets should be sufficient to provide the necessary behavioral health claims and encounters needed for the national evaluation. Maryland's somatic MCO encounter reporting has been shown to be quite robust, correct, and timely. Encounter data are used to determine medical loss ratios (the targets for which are set in MCO contracts) and in rate-setting. MCOs have significant incentives to provide complete and accurate encounter data.

Also as indicated, Maryland plans to have CCBHCs contract with a health data analytics firm that can extract claims and encounter data necessary for reporting of NCQA and NCQA-like items. Hilltop Institute, under contract to DHMH, is currently extracting MA claims for most of the agencies that have the capability to become CCBHCs for the Health Home initiative. Therefore, most Maryland providers that would seek to become CCBHCs have already embraced the culture of data-driven care and using HIT as part of continuous quality improvement.

Also as noted previously, it is planned that most of the data for reporting purposes will be sent from the data analytics tool, and data that is not claims-based will be gleaned from EHRs through interoperability. One such interoperability is in the active planning stages between ProAct and at least one of the major EHRs used in Maryland. In addition, the State will work with provider agencies to extract data directly from EHRs. All of the Maryland providers that have the capacity to become CCBHCs currently use only four different EHRs, so it is feasible to work with those vendors toward this goal. For data to be extracted from EHRs for direct reporting to DHMH, the planning phase time will be essential to assure that all required reporting elements can be accommodated in the database and that they are being properly collected, or that an alternative strategy is identified. Workgroups will be convened with all relevant parties to assure the consistent development of any reporting algorithms.

The current consumer perception of care surveys that are extensions of the MHISP surveys referenced in the RFA, though only currently used at a system level, can be tailored to and implemented in CCBHCs. (see attachment 2) Maryland also has consumer quality teams that have a history of obtaining such information and of assisting providers in identifying and remedying consumer issues that will be used in the evaluation process.